

GI Associates of New Hampshire

60 Commercial Street, Suite 404

Concord, NH 03301

Phone: 603-228-1763 Fax: 603-228-7088

AUTHORIZATION FOR OBTAINING PROTECTED HEALTH INFORMATION

Patient Information:

Name		
Street Address		
City	State	Zip Code
DOB	Phone Number	

Records To Be Obtained From:

Name		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Information To Be Obtained:

- Complete Copy of All Records Procedure Reports Pathology Reports
 Lab Reports Office Visits Inpatient/Outpatient Records
 Other (please specify) _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information derived above may be re-disclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payments or my eligibility of benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying GI Associates of NH except to the extent that action has been taken in reliance on this authorization. This authorization expires one year from date of signature.

I acknowledge that the data to be released may include material that is protected by law.

My initials and signature authorize release of the following type of information:

_____ drug/alcohol abuse information _____ mental health information
_____ HIV information _____ genetic testing

Signature of Patient or Representative

Date

Name of Personal Representative (if applicable) Relationship to Patient